

04. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with Subsection 160.03. (12-31-91)

162. ADMINISTRATIVELY NECESSARY DAY (AND). An Administratively Necessary Day is intended to allow a hospital time for an orderly transfer or discharge of recipient inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for NF level of care, or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. (7-1-94)

01. Documentation Provided. The hospital will provide the Department's designee complete and timely documentation prior to the patient's anticipated discharge date in order to be considered. Authorization for reimbursement will be denied for all untimely requests and tardy submittal of requested documentation. All requests for AND must be made in writing, or by telephone. Hospitals must make the documentation and related information requested by the Department's Medicaid Policy Section designee available within ten (10) working days of the date of the designee's request in order for subsequent payment to be granted. The documentation provided by the hospital will include, but is not limited to: (4-24-90)

- a. A brief summary of the patient's medical condition; and (4-24-90)
- b. Statements as to why the patient cannot receive the necessary medical services in a nonhospital setting; and (4-24-90)
- c. Documentation that the hospital has diligently made every effort to locate, without success, a facility or organization which is able and willing to deliver the appropriate care. Such evidence must include a list of facilities and organizations, the dates of contact, the names of the persons contacted, and the result of each contact. (4-24-90)

02. Limitation of Administratively Necessary Days. Each recipient is limited to no more than three (3) ANDs per discharge. In the event that a NF level of care is required, an AND may be authorized provided that the hospital documents that no NF bed is available within twenty-five (25) miles of the hospital. (7-1-94)

03. Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/MR rates are excluded from this calculation. (7-1-94)

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. (4-24-90)

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and (7-1-94)

c. The Department will pay the lesser of the established AND rate or a facility's customary charge to private pay patients for an AND. (4-24-90)

04. Reimbursement for Services. Routine services as addressed in Subsection 161.01.a. include all medical care, supplies, and services which are included in the calculation of nursing facility property and nonproperty costs as described in Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Medicaid Provider Reimbursement in Idaho." Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost

principles, except that reimbursement for prescription drugs will be in accord with Section 126. (7-1-94)

163. -- 164. (RESERVED).

165. RELATIONSHIP OF MEDICAL ASSISTANCE TO MEDICARE. (7-1-93)

01. General Relationship. In processing MA payments in behalf of recipients eligible for Medicare, the Department must determine the availability of resources from both Parts A and B of Title XVIII. The Department is to pay only the deductible and co-insurance amounts of those services covered by Parts A and B. (11-10-81)

02. "Buy-In" Coverage. The Department has an agreement with the Social Security Administration to pay the premiums for Part B of Title XVIII for each recipient eligible for Medicare and MA regardless of whether the client receives a financial grant from the Department. (6-1-91)

a. The effective date of the "Buy-In" for a client approved for MA and an AABD grant is the first month of eligibility for the AABD grant. (6-1-91)

b. The effective date of the "Buy-In" for a client approved for MA who also receives SSI, but not AABD, is the first month of eligibility for MA. (6-1-91)

c. The effective date of the "Buy-In" for a client approved for MA who does not receive an AABD grant or SSI is the first day of the second month following the month in which he became eligible for MA (third month of MA eligibility). (6-1-91)

d. After the effective date of the "Buy-In" it takes the Social Security Administration approximately three (3) months to update its records to show the Department's payment of the "Buy-In" premium. (11-10-81)

e. The Field Office will advise each recipient who is paying Part B Medicare premiums to discontinue payments beginning the month the "Buy-In" becomes effective. Policies for treatment of the "Buy-In" for determining eligibility for MA or AABD, grant amount for AABD, or patient liability are in Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)." Policies for treatment of the "Buy-In" for determining client participation of an HCBS client are found in Subsection 160.03.e. (7-1-94)

166. -- 169. (RESERVED).

170. RELATIONSHIP OF MEDICAL ASSISTANCE TO DEPARTMENT OF VOCATIONAL REHABILITATION. The Department has entered into agreements with DVR regarding areas of responsibility, joint planning, referrals, coordination, consultation, exchange of information and other matters of mutual concern. (11-10-81)

171. -- 179. (RESERVED).

180. INSPECTION OF CARE/UTILIZATION CONTROL IN LONG-TERM CARE FACILITIES. The following sections describe the Inspection of Care/Utilization Control (IOC/UC) process which must be followed for admission to and continued stay in a nursing facility (NF) or an Intermediate Care Facility for the Mentally Retarded (ICF/MR). (7-1-94)

01. Prepayment Screen and Determination of Entitlement to Medicaid Payment for NF Care and Services. (7-1-94)

a. A determination of medical entitlement will not be made until a medical history, physical, and plan of care signed and dated by the physician, a physician's certification for NF care, and the Level I screen and when

required, the Level II screen conducted by the Department indicating that NF placement is appropriate have been received in the Regional Medicaid Unit (RMU). The effective date of Medicaid payment will be no earlier than the date of the physician's certification for NF care. The level of care for Title XIX payment purposes is determined by the Regional Nurse Reviewer(s). Necessity for payment is determined in accordance with 42 CFR 456.271 and 42 CFR 456.372 and Section 1919(e) (7) (O) of the Social Security Act. (7-1-94)

b. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the RMU will not be earlier than the date the Level II screen is completed, indicating that NF placement is appropriate. (7-1-94)

## 02. Information Required for Determination. (7-1-94)

a. A complete medical evaluation current within thirty (30) days of admission, signed and dated by the physician (an electronic physician's signature is permissible), which includes: (7-1-94)

i. Diagnosis (primary and secondary); and (7-1-94)

ii. Medical findings and history; and (7-1-94)

iii. Mental and physical functional capacity; and (7-1-94)

iv. Prognosis; and (7-1-94)

v. A statement by the physician certifying the need for NF care and services. (7-1-94)

b. A physician's plan of care current within thirty (30) days of admission, signed and dated by the physician, which includes: (7-1-94)

i. Orders for medications and treatments; and (7-1-94)

ii. Diet and activities; and (7-1-94)

iii. Rehabilitative, restorative services, and special procedures, where appropriate; and (7-1-94)

iv. Plan of continuing care and discharge, where appropriate. (7-1-94)

c. Social information submitted by one (1) of the following: (7-1-94)

i. The physician; or (7-1-94)

ii. The applicant or family member; or (7-1-94)

iii. Health and Welfare agency worker; or (7-1-94)

iv. Facility social worker or R.N. (7-1-94)

d. An accurate Level I screen and, when required, a Level II screen. (7-1-94)

03. Criteria for Determining Need for NF Care. The recipient requires NF level of care when one or more of the following conditions exist and the skills of an R.N., P.T., or O.T. are required on a daily or regular basis: (7-1-94)

a. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and/or effectively performed only by

or under the supervision of a licensed nurse or licensed physical therapist. (7-1-94)

b. Skilled care is needed to prevent, to the extent possible, deterioration of the resident's condition or to sustain current capacities, regardless of the restoration potential of a resident, even where full recovery or medical improvement is not possible. (7-1-94)

c. When the plan of care, risk factors, and/or aggregate of health care needs is such that the assessments, interventions, or supervision of the resident necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and/or therapy notes. (7-1-94)

04. Skilled Nursing and Other Skilled Rehabilitative Services. Skilled services include, but are not limited to, the following: (7-1-94)

a. Services which could qualify as either skilled nursing or skilled rehabilitative services, which include but are not limited to: (7-1-94)

i. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet his needs, promote his recovery, and assure his medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that his recovery and/or safety could be assured only if the total care he requires is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. (7-1-94)

ii. Observation and assessment of the resident's changing condition. When the resident's condition is such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until his condition is stabilized, such services constitute skilled services. (7-1-94)

b. Services which qualify as skilled nursing services include but are not limited to the following: (7-1-94)

i. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; and (7-1-94)

ii. Nasopharyngeal feedings; and (7-1-94)

iii. Nasopharyngeal and tracheotomy aspiration; and (7-1-94)

iv. Insertion and sterile irrigation and replacement of catheters; and (7-1-94)

v. Application of dressings involving prescription medications and/or aseptic techniques; and (7-1-94)

vi. Treatment of extensive decubitus ulcers or other widespread skin disorders; and (7-1-94)

vii. Heat treatments which have been specifically ordered by a physician as part of treatment, and which require observation by nurses to adequately evaluate the resident's progress; and (7-1-94)

viii. Initial phases of a regimen involving administration of oxygen. (7-1-94)

c. Services which qualify as skilled rehabilitative services include, but are not limited to, the following: (7-1-94)

i. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; and (7-1-94)

ii. Therapeutic exercises or activities which, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; and (7-1-94)

iii. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and (7-1-94)

iv. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist; and (7-1-94)

v. Hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. (7-1-94)

05. Annual Utilization Control Review. Title XIX recipients in a NF are subject to an on-site review by Regional Nurse Reviewers within ninety (90) days of the date of medical entitlement, and on at least an annual basis thereafter to determine the need for continued NF care. Reviews will be conducted each calendar quarter on selected Title XIX recipients and other residents mandated by PASARR. (7-1-94)

a. Selection of recipients/residents to be reviewed each quarter: (7-1-94)

i. Recipients to be reviewed within ninety (90) days of date of initial medical entitlement; and (7-1-94)

ii. Recipients whose medical entitlement anniversary date falls within the quarter; and (7-1-94)

iii. Recipients/residents who have a Level II evaluation, with an admission anniversary date that falls within the quarter; and (7-1-94)

iv. Recipients who are receiving services that require a special Medicaid rate; and (7-1-94)

v. Recipients identified during previous reviews whose improvement may remove the need for continuing NF care. (7-1-94)

b. The on-site review conducted by the Regional Nurse Reviewer will include the following components: (7-1-94)

i. Entrance and exit conferences with appropriate facility personnel unless such conference is waived by the administrator; and (7-1-94)

ii. A review of the critical indicators in the Minimum Data Set section of the recipient's medical record; and (7-1-94)

iii. A visit with and observation of each recipient's condition; and (7-1-94)

iv. A determination whether the recipient continues to require nursing facility care; and (7-1-94)

v. A determination that those recipients or residents who warrant a Level II evaluation continue to require nursing facility care. (7-1-94)

06. Preadmission Screening and Determination of Entitlement for Medicaid ICF/MR Payment. Applications for Medicaid payment of an individual with mental retardation, or related condition, in an ICF/MR will be through a State's Regional Developmental Disabilities Centers (DDC). All required information necessary for a medical entitlement determination, including DDC's recommendation for placement and services, must be submitted to the Regional Medicaid Unit before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/MR level of care. (7-1-94)

07. Information Required for Determination. (7-1-94)

a. A complete medical evaluation, current within ninety (90) days of admission, signed and dated by the physician (an electronic physician's signature is permissible), which includes: (7-1-94)

i. Diagnosis (primary and secondary); and (7-1-94)

ii. Medical findings and history; and (7-1-94)

iii. Mental and physical functional capacity; and (7-1-94)

iv. Prognosis; and (7-1-94)

v. Mobility status; and (7-1-94)

vi. A statement by the physician certifying the level of care needed as ICF/MR for a specific recipient. (7-1-94)

b. An initial plan of care, current within ninety (90) days of admission, and, signed and dated by the physician which includes: (7-1-94)

i. Orders for medications and treatments; and (7-1-94)

ii. Diet; and (7-1-94)

iii. Professional rehabilitative and restorative services and special procedures, where appropriate; and (7-1-94)

c. A social evaluation, current within ninety (90) days of admission, which includes: (7-1-94)

i. Condition at birth; and (7-1-94)

ii. Age at onset of condition; and (7-1-94)

iii. Summary of functional status, e.g. skills level, ADL's; and (7-1-94)

iv. Family social information. (7-1-94)

d. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, which includes, but is not limited to: (7-1-94)

i. Diagnosis; and (7-1-94)

ii. Summary of developmental findings. Instead of a psychological, infants under three (3) years of age may be evaluated by a developmental disability specialist utilizing the developmental milestones congruent with the age of the infant; and (7-1-94)

iii. Mental and physical functioning capacity; and (7-1-94)

iv. Recommendation concerning placement and primary need for active treatment. (7-1-94)

e. An initial plan of care developed by the admitting ICF/MR. (7-1-94)

08. Criteria for Determining ICF/MR Care. To meet Title XIX entitlement for intermediate care for the mentally retarded (ICF/MR) level of care, the person must be financially eligible for Medicaid and meet all of the following criteria: (7-1-94)

a. The person must have a primary diagnosis of mental retardation or have a related condition defined in Manual Section 181.09; and (7-1-94)

b. The person must require and receive intensive inpatient active treatment as defined in Section 181.10, in an ICF/MR, to advance or maintain his functional level; or (7-1-94)

c. The person would require the level of care provided in an ICF/MR in the absence of available intensive alternative services in the community. (7-1-94)

09. Definition of Mental Retardation or Related Condition. For the purposes of these rules, the term "mental retardation or related condition" means a severe, chronic disability of a person which appears before the age of twenty-two (22) years of age; and (7-1-94)

a. Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation. This condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and (7-1-94)

b. Is likely to continue indefinitely; and (7-1-94)

c. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: (7-1-94)

i. Self-care; or (7-1-94)

ii. Receptive and expressive language; or (7-1-94)

iii. Learning; or (7-1-94)

iv. Mobility; or (7-1-94)

v. Self-direction; or (7-1-94)

vi. Capacity for independent living; or (7-1-94)

vii. Economic self-sufficiency. (7-1-94)

## 10. Determination of Need for Active Treatment. (7-1-94)

a. Active treatment, as used in these rules, is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Mental Retardation Professional (QMRP) directed toward: (7-1-94)

i. The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or (7-1-94)

ii. The prevention or deceleration of regression or loss of current functional status. (7-1-94)

b. Active treatment does not include: (7-1-94)

i. Parenting activities directed toward the acquisition of age-appropriate developmental milestones; or (7-1-94)

ii. Services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; or (7-1-94)

iii. Interventions that address age-appropriate limitations; or (7-1-94)

iv. General supervision of children who's age is such that such supervision is required by all children of the same age. (7-1-94)

c. The following criteria/components will be utilized when evaluating the need for active treatment: (7-1-94)

i. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the recipient and the interventions needed; and (7-1-94)

ii. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. (7-1-94)

11. Recertification for ICF/MR Level of Care. A physician or physician's assistant or nurse practitioner must recertify the resident's continuing need for ICF/MR placement by written, signed, and dated documentation in the resident's medical record. Documentation will consist of the completion of a recertification statement on the "Recertification of Care" HW0209 and/or the entry of all required information on the physician's order sheet. Such documentation shall be accomplished no later than every three hundred and sixty-five (365) days from the most recent such certification. (7-1-94)

a. It is the responsibility of the ICF/MR to assure that the recertification is accomplished by the physician, physician's assistant or nurse practitioner no later than every three hundred and sixty-five (365) days. Should the Medicaid Program receive a financial penalty from the Department of Health and Human Services due to the lack of appropriate recertification on the part of an ICF/MR, then such amount of money will be withheld from facility payments for services provided to Medicaid recipients. For audit purposes, such financial losses are not reimbursable as a reasonable cost of patient care. Such losses cannot be made the financial responsibility of the Department's client. (7-1-94)

b. The physician's, physician's assistant's, or nurse practitioner's recertification will be monitored by the IOC† at the time of the annual on-site review. (7-1-94)

12. Annual Inspection of Care Review. Each Title XIX resident will receive an on-site comprehensive inspection of care review at least annually. (7-1-94)

a. Each Title XIX resident's medical record and plan of care will be reviewed to determine the quality of care and services rendered to the resident. The plan of care must include: (7-1-94)

i. Behaviorally stated measurable goal and objectives; and (7-1-94)

ii. An integrated program of individually designed activities, experiences, and therapies necessary to achieve such goals and objectives. (7-1-94)

b. Observation and/or interview with each Title XIX resident as deemed appropriate; and (7-1-94)

c. A determination of each resident's level of care. The IOCT determines the appropriateness of level of care for the purpose of Medicaid payment; and (7-1-94)

d. Evaluation of services provided by the facility to determine that each individual resident's needs are met; and (7-1-94)

e. Verification of recertifications to determine if the physician, physician's assistant, or a nurse practitioner recertified the resident's continuing need for ICF/MR care within the required time frames and is signed and dated by the certifying physician, physician's assistant, or a nurse practitioner. (7-1-94)

13. Inspection of Care Reports. (7-1-94)

a. The IOCT will prepare a full and complete report following the annual on-site review in each ICF/MR. The report will be forwarded to the following no later than thirty (30) days after the on-site review: (7-1-94)

i. Facility administrator; and (7-1-94)

ii. Facility Utilization Review Committee; and (7-1-94)

iii. Medicaid single state agency; and (7-1-94)

iv. Agency responsible for licensing and certification. (7-1-94)

b. A formal response is required from the facility regarding the IOC deficiencies requiring correction. The Department will specify the amount of time a facility will be allowed to respond which will not exceed thirty (30) days. An extension of time may be granted, not to exceed an additional thirty (30) days if the Department concludes that such an extension is in the best interests of the residents of the facility. The formal response is to be returned to the Regional Medicaid Unit. (7-1-94)

14. Level of Care Change. Level of care is the level of NF or ICF/MR services provided to meet the patient's/resident's medical, nursing, rehabilitative and/or habilitative care needs. (7-1-94)

a. If during an on-site review of a resident's medical record and an interview with or observation of the resident an IOC/UC reviewer determines there is a change in the resident's status and the resident no longer meets criteria for NF or ICF/MR care, the tentative decision is: (7-1-94)

i. Discussed with the facility administrator and/or the director of nursing services; and (7-1-94)

ii. The patient's/resident's physician is notified of the tentative decision; and (7-1-94)

iii. The case is submitted to the Regional Review Committee for a final decision; and (7-1-94)

iv. When NF or ICF/MR care is determined to be not necessary for applicants or no longer necessary or appropriate for a recipient, the Regional Medicaid Unit will notify the local Eligibility Field Office utilizing the HW0083 form that the applicant/recipient is not medically entitled to Medicaid payment. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the recipient by the Eligibility Examiner. (7-1-94)

15. Appeal of Determinations. The resident or his representative may appeal the decisions as set forth in Idaho Department of Health and Welfare Rules Title 5, Chapter 3, Section 05.0300 et seq. and Section 05.03.301, "Rules Governing Contested Cases and Declaratory Rules". (7-1-94)

16. Regional Review Committee. A committee established in each region to provide thorough and impartial reviews and final determinations on cases submitted by the Regional Medicaid Unit which includes but is not limited to: (7-1-94)

a. A resident's continued medical entitlement to NF or ICF/MR care that is no longer recommended by the Regional Nurse Reviewer. (7-1-94)

b. Applications for medical entitlement where the level of care, client safety, or the effectiveness of care appears to be questionable. (7-1-94)

c. All denial decisions recommended by the Regional Nurse Reviewer. (7-1-94)

d. The Committee may continue, terminate the client's Medicaid payments, or recommend a supplemental on-site visit by the Regional Nurse Reviewer if it is deemed necessary. (7-1-94)

e. No review of a denial of payment is required of the Committee when the denial is based on the level of care determination by the attending physician, i.e. the physician documents that the applicant/recipient does not require NF or ICF/MR level of care. (7-1-94)

f. The Regional Review Committee shall be composed of the following: (7-1-94)

i. A consultant physician; and (7-1-94)

ii. Two (2) registered nurses; and (7-1-94)

iii. A social worker when necessary; and (7-1-94)

iv. A qualified mental retardation professional (QMRP) or a qualified mental health professional (QMHP) when necessary; and (7-1-94)

v. When appropriate, other health and human service personnel responsible to the Department as employees or consultants. (7-1-94)

17. Supplemental On-Site Visit. The Regional Nurse Reviewer(s) may conduct UC supplemental on-site visits in a NF, or IOC supplemental on-site visits in an ICF/MR when indicated. Some indications may be but are not limited to: (7-1-94)

a. Follow-up activities; and (7-1-94)